STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185133	A. BUILDING _____ B. WING _____	02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWATER POINTE	100 W. RAMSEY DAWSON SPRINGS, KY 42408

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F 000	INITIAL COMMENTS AMENDED 03/08/12 An annual survey and an abbreviated survey (KY #17770) was conducted on 02/07/12 through 02/10/12. Immediate Jeopardy was identified on 02/10/12 at 483.13 Resident Behavior and Facility Practices, at 483.25 Quality of Care and at 483.75 Administration. An extended survey was conducted on 02/13/12 through 02/14/12. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and at 483.25 Quality of Care. KY #17770 was substantiated with deficiencies cited. The facility failed to ensure a thorough investigation was conducted with results reported timely, timely reporting of sexual abuse/exploitation allegation to officials, and failed to prevent further potential abuse involving Resident #4. On 09/14/11, Resident #4, who the facility had assessed and identified as having a history of sexually inappropriate behaviors, was observed by facility staff to be in his/her roommates' bed, naked and "humping" his/her roommate (Resident #21). SRNA #2 intervened and Resident #4 returned to his/her bed. Registered Nurse (RN) #2 was informed about the incident and she notified the Assistant Director of Nursing (ADON). RN #2 started every fifteen (15) minute checks on Resident #4. There was no evidence the facility followed their "Abuse" policy/procedure to ensure the resident's safety and protection was first assured and the residents were separated, as the State Registered Nurse Aide (SRNA) and the Certified Medication Technician (CMT) left both Resident #4 and Resident #21 alone in the room together. The	F 000	 DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Tradewater Pointe, d/b/a Tradewater Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Tradewater Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Tradewater Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5-1-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 facility only initiated every fifteen minute checks, thus leaving the perpetrator (Resident #4) access to Resident #21 and all residents of the unit without supervision. Based on the facility's failure to follow their own policy, this presented the potential for abuse to recur for Resident #4 and to occur with other residents in the facility. Furthermore, the facility implemented pharmacological interventions to reduce sexual desire even though the psychiatrist had determined this drug ineffective. Additionally, the facility's investigation failed to identify Resident #4's behavior on 09/14/11 as an allegation of abuse and failed to determine that the resident's actions were of sexual nature which prevented the facility from taking actions to protect residents from abuse. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/10/12 and determined to exist on 09/14/11 through 02/13/12. An acceptable Allegation of Compliance (AoC) was received on 02/13/12. Immediate Jeopardy was removed, effective 02/14/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's	F 157	**F157** **Resident #6** **1. Corrective action:** Resident assessed and treated on 1-26-12 by hospital and Primary Physician reviewed on 2-17-12. Licensed staff were inserviced by theDON on 2-10-12 and 3-3-12 to:immediately consult with a resident's physician when there is a need to alter treatment for a resident such as the reinsertion of a PEG tube or problems with a PEG tube, to follow the facility Change In Condition Policy and to follow the Enteral Nutrition Policy.	

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F 157	Continued From page 2 physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately consult with the resident's physician a need to alter treatment significantly for one resident (#6), in the selected sample of fifteen residents, related to complications of the resident's Percutaneous Endoscopic Gastrostomy (peg) tube site. The facility failed to follow their change in resident condition/status policy and the Enteral Nutrition policy. The facility staff was knowledgeable	F 157	**2. ID of Others at Risk:** All residents are at risk for a need to change treatment. DON/ADON and Compliance Nurse reviewed all residents on 3-1-12 and no residents were found to have a need for change in treatment or notification of a physician that had not been contacted appropriately. Only two other residents with a PEG tube in the building. On 3-1-12 the DON reviewed tube fed residents with no needs for change in tx or need for physician contact noted at present. **3. Prevention measures:** Licensed staff were inserviced by the DON on 2-10-12 and 3-3-12 to immediately consult with a resident's physician when there is a need to alter treatment for a resident, follow the Change In Condition and the Enteral Nutrition Policy. **4. Monitor:** The DON will monitor residents change of status utilizing the Resident Status Change –Notification CQI Tool and report findings in the monthly Continuous Quality Improvement (CQI) meeting for three months, then quarterly. **5. Date of Correction:** **See exhibit #1,2,3**	3-7-12

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regarding Resident #6's history of peg tube complications; however, on 01/13/12 and 01/15/12, the facility staff reinserted Resident #6's peg tube without notification of the physician. Additionally, on 01/26/12 the facility staff failed to notify the physician at 4:15 AM when there was yellow drainage from the peg site. At 4:15 PM, the facility transferred the resident to the hospital, who was experiencing severe abdominal pain with excessive amounts of greenish/brown drainage from the tube site.

Findings include:

A review of the facility's policy/procedure, "Enteral Nutrition," revised 10/21/10, revealed the procedure for gastrostomy tube placement included to obtain a physician's order for insertion.

A review of the facility's policy/procedure, "Change in Resident Condition or Status," revised 03/26/10, revealed the facility should timely notify the attending physician of changes in the resident's medical condition. The nurse supervisor/charge nurse would notify the resident's attending physician or on-call physician when there was a need to alter the resident's medical treatment significantly.

A record review revealed Resident #6 was originally admitted to the facility on 03/16/09 with diagnoses to include Nausea, Esophageal Reflux, and Gastrostomy. A review of the quarterly Minimum Data Set (MDS), dated 11/23/11, revealed the resident received a tube feeding.

A review of the Nurse's Notes, dated 01/10/12,

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F 157	Continued From page 4	F 157		

revealed the resident's peg tube was dislodged. A review of the Physician's orders, dated 01/10/12, revealed "reinsert peg tube 18 fr with 30 cc balloon under sterile technique." Further review of the Nurse's Notes, dated 01/13/12 and 01/15/12, revealed the peg tube was dislodged again, with reinsertion of the tube completed on both days; however, there was no evidence of a physician's order to reinsert the resident's peg tube on 01/13/12 or 01/15/12.

An interview with Registered Nurse (RN) #1, on 02/08/12 at 7:00 PM, revealed she reinserted the resident's peg tube, on 01/13/12; however, she did not notify the physician.

An interview with Licensed Practical Nurse (LPN) #3, on 02/09/12 at 10:40 AM, revealed she was the resident's nurse, on 01/15/12. The resident's peg tube was dislodged while administering medications, and RN #1 reinserted the peg tube. She revealed the physician was not notified about the reinsertion, due to an order being received on 01/10/12. She revealed it was her understanding that the order was written to replace the peg tube as needed.

An interview with Resident #1's Primary Physician, on 02/08/12 at 2:45 PM, revealed nursing staff should have notified her if the resident's peg tube was dislodged.

An interview with the Director of Nursing (DON), on 02/09/12 at 7:15 PM, revealed she expected the staff to reinsert the peg tube to ensure the site did not close, but they should also notify the physician.

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F 157	Continued From page 5 Further review of the Nurse's Notes, dated 01/25/12 at 12:45 PM, revealed Resident #6 returned to the facility after being examined by the endoscopy department (at the hospital) related to peg tube complications. It was determined by endoscopy the resident's peg tube was functioning properly and orders were resumed. A review of the Nurse's Notes, dated 01/26/12 at 4:15 AM, revealed the resident's peg tube was assessed at that time with a moderate amount of yellow drainage noted around the tube. There was no documented evidence of physician notification. Additional record review revealed, on 01/26/12 At 4:15 PM, the resident was in severe abdominal pain with excessive amounts of greenish/brown drainage around the peg tube. The resident was sent to the emergency room at that time, and admitted with peg tube complications. A review of the Consultation report, dated 01/27/12, revealed treatment during hospitalization consisted of repositioning of the peg tube due to obstruction. An interview with RN #1, on 02/08/12 at 7:00 PM, revealed, on 01/26/12 at 4:15 AM, there was drainage around the resident's peg tube with a slow leakage, but not "major drainage." She revealed drainage was not "normal," but the resident had a history of complications from the peg tube. She revealed the physician was not notified regarding the peg tube drainage. An interview with Resident #1's Primary Physician, on 02/08/12 at 2:45 PM, revealed she should have been notified about the moderate yellow drainage, on 01/26/12 at 4:15 AM, as she would have sent the resident to the emergency room at that time.	F 157		

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F 157	Continued From page 6 An interview with the DON, on 02/09/12 at 7:15 PM, revealed the physician should have been notified about the drainage around the resident's peg tube, on 01/26/12 at 4:15 AM.	F 157		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	**F225** **Resident #4** **1. Corrective action:** Inservice was held on this date, February 10, 2012, for all Charge Nurses, Administrative Nurses, Social Services Director, Administrator, and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report. The initial inservice was provided by the Corporate Compliance Nurse with any remaining persons being inserviced by the Administrator, DONor Administrative Nurses (ADON or Compliance Nurse) on an individual basis prior to their next shift. Corporate Compliance Nurse trained administrator that all alleged violations	

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F 225	Continued From page 7 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy/procedure, it was determined the facility failed to ensure that an allegation of sexual abuse/exploitation was reported immediately to officials in accordance with State law through established procedures (including State survey and certification agency). The facility failed to ensure a thorough investigation was conducted with results reported timely, timely reporting of sexual abuse/exploitation allegation to officials, and failed to prevent further potential abuse involving one resident (#4), in the selected sample of fifteen residents. On 09/14/11, facility staff observed Resident #4 in his/her roommates' bed, naked and "humping" the roommate. Based on the facility's failure to follow their own policy, this presented the potential for abuse to recur for Resident #4 and to occur with other residents in the facility. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/10/12 and determined to exist on 09/14/11 through 02/13/12. An acceptable Allegation of Compliance (AoC) was received on 02/13/12. Immediate Jeopardy was removed, effective 02/14/12, as	F 225	involving mistreatment, neglect or abuse (specific to F225) must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting. Investigation and reporting information along with supervision information was relayed to the Charge Nurses, Administrative Nurses, Social Services Director and Department Leaders by the Administrator after being inserviced by the Corporate Compliance Nurse. Resident was placed on one to one supervision this date, February 10, 2012. **2. ID Of Other Residents at Risk:** All residents are considered to be at risk although resident #4 is unsteady on their feet and ambulation is self-limited. All	

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F 225	Continued From page 8 alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F323 and F490) Findings include: A review of the facility's policy/procedure, "Resident Abuse, Neglect and Exploitation," dated 04/12/10, revealed it is the goal of the facility to have a process in place to protect the health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation an injuries of unknown origin. If a resident to resident altercation occurs, the resident's safety and protection will first be assured. The residents shall be separated from each other and the families and physician shall be notified. An investigation will be performed to determine if abuse has occurred. If it is determined that abuse has occurred, an evaluation of the abusing resident shall be completed to determine if there is a problem that would require medical intervention. The incident will be viewed as a reportable incident with proper protocol followed and the appropriate agencies will be notified. A record review revealed Resident #4 was admitted to the facility on 01/02/02 with diagnoses to include Late of Effects of Fracture of Skull and Face Bones, Intermittent Explosive Disorder, Depressive Disorder and Senile Dementia. A	F 225	residents assessed by Licensed Nursing Staff utilizing observation and interview. (See Residents at Risk for Abuse Assessment form) In an effort to reduce risk to residents, the Corporate Compliance Nurse is to be notified of any allegation of abuse immediately of the incident along with proper reporting to DCBS and OIG. All resident incident reports are reviewed in regularly scheduled Morning Staff Meetings M-F. Any incident reports containing allegations of abuse will be forwarded to the Concord Health Systems Corporate Office for review by the Corporate Compliance Nurse to assure that protection of the resident, investigation and reporting have been accomplished correctly. **3. Prevention measures:** All allegations of abuse will be reviewed with the Corporate Compliance Nurse immediately of the event. The Corporate Compliance Nurse is to be notified of any allegation of abuse immediately of the incident along with proper reporting to DCBS and OIG. All resident incident reports are reviewed in regularly scheduled Morning Staff Meetings M-F at the facility. Any incident reports containing allegations of abuse will be forwarded to the Concord Health Systems	

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F 225	Continued From page 9 review of the quarterly Minimum Data Set (MDS), dated 12/22/11, revealed the resident was severely cognitively impaired and rarely made decisions. A review of the Mood and Behavior Patterns, dated 09/11, revealed staff documented on 09/01/11, 09/08/11, 09/14/11 (6 AM-2 PM shift and 2 PM-10 PM shift), 09/17/11, and 09/22/11, that Resident #4 displayed inappropriate sexual behavior. An interview with the psychiatrist, on 02/13/12 at 11:22 AM, revealed he was familiar with Resident #4 since admission to the facility and had treated him/her afterwards. Resident #4 had documented episodes of walking into the dayroom of the facility naked in full view of female residents and visitors in the room. There were also documented episodes of the resident asking other residents and visitors sexually inappropriate questions in 5/4/10. The resident had a history of alcoholism and he had learned these resident's didn't sensor their behavior and acted on impulse. The resident had cognitive deficits and had previously been on Depo-Provera injections for sexually inappropriate behavior. The injections were discontinued in July 2011 related to not seeing any effectiveness of the medication. At the time he completed a review of his/her medications, he was urged to reduce the number of medications the resident was taking. He revealed those medications identified as not helping Resident #4 were discontinued. There was clear evidence of sexually inappropriate behavior and some type of intervention was warranted to reduce or minimize the sexually inappropriate behavior. The staff would call and a medication was prescribed; however, the staff would call back stating the resident was lethargic	F 225	Corporate Office for review by the Corporate Compliance Nurse to assure that protection of the resident, investigation and reporting have been accomplished correctly. Inservice was held on this date, February 10, 2012, for all Charge Nurses, Administrative Nurses, Social Services Director, Administrator, and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report. The initial inservice was provided by the Corporate Compliance Nurse with any remaining persons being inserviced by the Administrator, DON or Administrative Nurses (ADON or Compliance Nurse) on an individual basis prior to their next shift. Corporate Compliance Nurse trained administrator that all alleged violations involving mistreatment, neglect or abuse (specific to F225) must be reported to other officials such as the DCBS and	

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F 225	Continued From page 10 and having increased falls. He revealed the staff were his eyes and ears but he was not aware Resident #4 was started back on the Depo-Provera injections for sexual aggression. An interview with the DON, on 02/09/12 at 7:41 PM, revealed Resident #4 made comments to the staff like "give me a kiss" or tried to put his/her arm around the staff. He/she came into the halls wearing his/her hipsters and the staff redirected him/her. She stated there were not interviews with any other staff other than SRNA #2, nor did she talk to the residents in the facility because SRNA #2 was the only witness to the incident. They did not determine there was willful intent but rather confusion on Resident #4's behalf. The investigation report was completed after the interview with the witness. She determined the incident was not abuse, but rather the resident was confused and wanted to lay down. There was no reporting to other agencies because it was determined not to be abuse. The abuse/neglect policy/procedure revealed "separate the residents" and that meant to move them apart. An interview with SRNA #4, on 02/10/12 at 12:34 PM, revealed Resident #4 was very sexual and tried to grab staff inappropriately, such as between the legs and breast. Whenever it happened, she informed the charge nurse about the incident. They spoke to the resident and told him/her not to act like that. A review of the nurse's notes, dated 09/14/11 at 10:00 PM, and an interview with SRNA #2, on 02/09/12 at 5:10 PM, revealed she observed Resident #4 "humping" on his/her roommate	F 225	OIG. There must be evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting. Investigation and reporting information along with supervision information was relayed to the Charge Nurses, Administrative Nurses, Social Services Director and Department Leaders by the Administrator after being inserviced by the Corporate Compliance Nurse. **4. Monitoring:** Daily monitoring of incident reports by Administrative Nurses that includes the DON, ADON, and Compliance Nurse, 7 days per week for three months. Any problems reported immediately to the Corporate Compliance Nurse. Incidents are also reviewed M-F in the Morning staff meetings and monthly in the facility Continuous Quality Improvement meeting on going. **5. Date Corrected:**	**2-15-12**

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(Resident #21). Resident #4 was laying in the bed behind the roommate without any clothes on and the roommate was wearing a pair of hipsters. There was no blanket between the residents and he/she was "humping" on the roommate. SRNA #2 called the resident's name and asked what he/she was doing. Resident #4 got up from the victim's bed, ambulated back to his/her bed and got dressed again. She left the room and the residents were left unsupervised. SRNA #2 reported the incident to the charge nurse on duty (RN #2). Registered Nurse (RN) #2 documented an SRNA reported to her she witnessed Resident #4 naked and in the bed with the roommate "humping" up on him/her. The roommate was dressed and under the covers with his/her eyes closed. Resident #4 was redirected and dressed. She could not recall for certain if she had received reports of Resident #4 getting into bed with other residents but it was common knowledge. The Assistant Director of Nursing (ADON) was notified and advised to place the resident on every fifteen (15) minute checks for safety. Staff was directed to check on Resident #4 every fifteen (15) minutes. Additionally, she reported staff caught the resident in bed with other residents in the past, but he/she was not "humping" on them. The staff redirected Resident #4 and he/she got up from the bed. The resident cursed at the staff but he/she was compliant. The staff has caught the resident in the bed with a resident of the same gender. The staff intervened with redirection and they documented the behavior continued with no other approach implemented. During the month of 10/11, staff documented one incident on the 12th of the resident displaying inappropriate sexual behavior. The staff responded with redirection

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F 225	Continued From page 12	F 225		

and it was effective. During the month of 11/11, staff documented on the 16th, 18th and 23rd, Resident #4 displayed inappropriate sexual behavior. The staff responded with redirection; however, they documented the behavior continued with no other approach implemented. During the month of 12/11, staff documented on the 5th and 6th that Resident #4 displayed inappropriate sexual behavior. The staff intervened with redirection and they documented the behavior continued with no other interventions implemented.

An interview with Certified Medication Technician (CMT) #1 on 02/09/12 at 6:14 PM and 02/10/12 at 10:21 AM, revealed she and an aide walked into the room and observed Resident #4 trying to perform a sex act with his/her roommate (Resident #21). Resident #4 acted like he/she was trying to have sex with the roommate (Resident #21). The room was dark and she was unable to recall if Resident #4 had clothes on or if there were covers between the residents. They intervened, she guided Resident #4 back to his/her bed and left the room. SRNA #2 informed the charge nurse and the CMT documented the behavior on the resident's behavior sheet.

A review of the facility's investigation, dated 09/15/11, revealed Resident #4 crawled in bed with his/her roommate (Resident #21), on 09/14/11 at 10:50 PM. Registered Nurse (RN) #2 reported this incident to the Assistant Director of Nursing (ADON), who was the Administrative nurse. The ADON advised RN #2 to place Resident #4 on fifteen (15) minute checks at that time. There was no evidence the facility separated the residents per their policy/procedure

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for the protection of the resident related to resident to resident abuse. Rather the facility continued to allow the resident to reside in the same room with only every fifteen minute checks performed by the staff. The DON interviewed SRNA #2 who reported seeing Resident #4 close his/her bedroom door. SRNA #2 went to the resident's room and upon entrance to the room, she noticed Resident #4 was in Resident #21's bed with him/her. Resident #21 was facing the wall and Resident #4 was facing Resident #21. Resident #4 appeared to be moving the middle of his/her body in the direction Resident #21 was laying. SRNA #2 asked Resident #4 what he/she was doing and Resident #4 got out of the bed. Resident #21 remained quiet with his/her eyes closed. Resident #4 had a diagnoses of closed head injury and mild mental retardation. Prior to Resident #21's admission to that room, Resident #4 resided in the room alone and he/she frequently got into the empty bed. Resident #4 had a history of getting in others' beds just to rest, and had a history of shutting the door to his/her room. The day prior to this incident, the ADON walked by the room and noticed Resident #4 sitting on Resident #21's empty bed. The incident appeared to be a "sexual advance" as reported by SRNA #2; however, interview with SRNA #2 revealed she thought the incident could be thought of as abuse with Resident #4's history of sleeping in that bed, and being observed in the empty bed the day before, it was more of a habit. With the diagnoses of closed head injury and mental retardation, Resident #4 was just trying to lay down. Resident #4 was positioning himself/herself in the bed, which would explain any movement coming from him/her. Additionally, the facility provided no evidence of

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F 225	Continued From page 14 interviewing alert and oriented residents in the facility to determine if Resident #4 attempted to get in the bed with other residents or display sexually inappropriate behavior. There were no interviews with other staff working in the facility to determine if they observed the resident getting into bed with other residents. An interview with RN #2, on 02/09/12 at 5:56 PM, revealed SRNA #2 reported to her Resident #4 was observed "humping" on his/her roommate (Resident #21). When an incident related to abuse occurred, then she was supposed to notify the Director of Nursing (DON). RN #2 assessed both of the residents and did not observe any injury. An interview with the ADON, on 02/09/12 at 7:00 PM, revealed she did not recall being notified on the night of 09/14/11,when the incident with Resident #4 occurred; however, it was documented that the staff called her. She advised the staff to start the resident on fifteen (15) minute checks. She recalled she was told the next day there was potential inappropriate behavior by Resident #4 directed toward his/her roommate (Resident #21). She stated Resident #4 did not have a history of sexually inappropriate behavior and was demented. The resident previously resided in the first bed of the bedroom and got turned around often. He/she got in the empty bed in his/her room and staff redirected him/her to the other bed in the room. The incident was discussed in the morning meeting, on 09/15/11, and they came to the conclusion no abuse occurred. The resident was confused and got into the wrong bed.	F 225		

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F 225	Continued From page 15 An interview with the Administrator, on 02/09/12 at 8:10 PM, revealed she was the Abuse Coordinator and completed the investigations in the facility; however, she did not complete the investigation for the incident, on 09/14/11, involving Resident #4. The DON completed the investigation, but she reviewed it and identified no problem with the investigation. No other individuals were interviewed related to the incident because there was only one witness to the incident. We determined there was no abuse identified because Resident #4 was confused and he/she was trying to get in the bed. There was nothing sexual in nature about the incident. The staff moved Resident #4 back to his/her bed and they put him/her on 15 minute checks. The facility determined the resident thought it was his/her bed but as a precaution, they put him/her on extra supervision. An acceptable Allegation of Compliance was received on 02/13/12 and detailed the following: On 02/10/12, the Administrator was trained by the Corporate Compliance Nurse all alleged violation involving mistreatment, neglect, or abuse (specific F225) must be reported to other officials such as the Department of Community Based Services (DCBS) and Office of Inspector General (OIG). There must be evidence that all alleged violation are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting. On 02/10/12, all Charge Nurses, Administrative Nurses, Social Services Director, Administrator	F 225		

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F 225	Continued From page 16 and Department Leaders was inserviced on the Abuse, Neglect and Exploitation Policy. Additionally, nurse aide rounds were established and conducted every hour to view the residents, know their whereabouts and assure their environment was free of accident hazards. All residents were assessed by Licensed Nursing staff utilizing the Residents at Risk for Abuse Assessment form, observation and interview. On 02/10/12, Resident #4 was placed on one to one supervision and remained on continuous monitoring. Verification of the removal of Immediate Jeopardy was completed as follows: Review of the Residents at Risk for Abuse Assessment revealed all residents within the facility had an assessment completed on 02/13/12. Investigation and reporting information along with supervision information was relayed to the Charge Nurses, Administrative Nurses, Social Services Director and Department Leaders by the Administrator after being inserviced by the Corporate Compliance Nurse. A review of the inservicing form, dated 02/10/12, and interview with the Administrator, revealed she was re-educated on 02/10/12 related to ensuring all allegations were thoroughly investigated and reported to the other officials. Interview with Licensed Staff and aides, on 02/13/12, revealed they had received inservicing	F 225		

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F 225	Continued From page 17 on 02/10/12 related to abuse, separating the residents, placing the aggressor on one to one supervision and notifying the Administrative Nurse on-call. Additionally, the nurses would start the investigation and get statements from all staff working at the time of the incident. They would also interview the residents to see if they had any knowledge of the incident. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Based on interview and record review, it was determined Immediate Jeopardy was identified on 02/10/12 and determined to exist on 09/14/11 through 02/13/12. An acceptable Allegation of Compliance (AoC) was received on 02/13/12. Immediate Jeopardy was removed, effective 02/14/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F323 and F490)	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246	**F246** **Resident #13** **1. Corrective Action:** Resident #13 was re-interviewed by the Food Service Supervisor (FSS) on 2-10-12 to update likes and dislikes for tray card. A review of Resident Rights was presented to all employees by the	

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F 246	Continued From page 18 by: Based on observation, interviews, record review, and review of the Resident Rights, it was determined the facility failed to ensure each resident received services in the facility with reasonable accommodations of individual preferences for one resident (#13) in the selected sample of fifteen residents. On 02/07/12, observation during the evening meal revealed the facility failed to honor Resident #13's food preferences and failed to offer a substitute. Findings include: A review of the "Resident Rights", undated, revealed residents have the right to receive services considering their special needs, likes, and dislikes. A record review revealed Resident #13 was readmitted to the facility 05/07/10. A review of the quarterly Minimum Data Set (MDS), dated 01/12/12, revealed the facility identified the resident to be moderately cognitively impaired. A meal observation, on 02/07/12 at 5:20 PM, revealed Resident #13 was served chicken; however, the resident's tray card specified chicken as a dislike. The resident voiced he/she did not like chicken, and Licensed Practical Nurse (LPN) #5 stated "that's unusual" and walked away from the resident without offering a substitute. A review of the resident's tray card for lunch and dinner, obtained 02/09/12 at 2:15 PM, revealed the resident disliked chicken. An interview with LPN #5, on 02/07/12 at 5:40	F 246	~~Corporate Public Relations Specialist on~~ 3-6-12 explaining that residents have the right to receive services considering their special needs, likes, and dislikes (including food preferences). Dietary employees educated by RD on March 9, 2012, regarding the honoring of food preferences and the offering of substitutes. Dietary Aide #1 was re-educated by the Food Service Supervisor on 3-2-12 to check trays against their tray card for accuracy before sending out of the kitchen for service. Nursing employees were educated by the DON in Charge Nurse Meeting on 3-10-12 regarding the honoring of food preferences and the offering of substitutes. Re-education was provided to Licensed Nurse #5 on 3-3-12 by ADON regarding the requirement to offer residents food substitutes if a resident expresses dislike of a particular food. **2. ID of Other Residents at Risk:** All residents on a diet by mouth are at risk for likes and dislikes not being honored. A survey was given to all interviewable residents receiving a po diet by the Corporate Public Relations specialist on 3-6-12 to identify residents experiencing problems regarding the	

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~~facility food service or the honoring~~ of preferences with tray card changes made by the Food Service Supervisor after the survey.

All interviewable residents re-interviewed for likes and dislikes by the FSS and the Assistant FSS and completed by 3-9-12. Changes were made by request to likes and dislikes and tray cards updated by FSS.

3. Prevention Measures:

Resident #13 was re-interviewed by FSS on 2-10-12 to update likes and dislikes for tray card.

A review of Resident Rights was presented to all employees by the Corporate Public Relations Specialist on 3-6-12 explaining that residents have the right to receive services considering their special needs, likes, and dislikes (including food preferences).

Dietary employees educated by RD on March 9, 2012, regarding the honoring of food preferences and the offering of substitutes.

Dietary Aide #1 was re-educated by the Food Service Supervisor (FSS) on 3-2-12 to check trays against their tray card for accuracy before sending out of the kitchen for service.

Continued from page 19 of 2567, F226

Nursing employees were educated by the ~~DON in Charge Nurse Meeting~~ on 3-10-12 regarding the honoring of food preferences and the offering of substitutes.

Re-education was provided to Licensed Nurse #5 on 3-3-12 by ADON regarding the requirement to offer residents food substitutes if a resident expresses dislike of a particular food.

4. Monitor:

The honoring of resident food preferences will be monitored through the monthly CQI using the Meal Satisfaction Survey Tool. Findings will be reported to the facility CQI meeting monthly x 3 months and then quarterly.

5. Correction Date: 3-11-12 ✓

See exhibits #4a-4s, 5a-5d,

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F 246	Continued From page 19 PM, revealed substitutes were available in the kitchen, but the resident had indicated he/she would eat the other items on the meal tray and was not "really hungry for anything else." However, an observation was made on 02/07/12 at 5:30 PM, where Resident #13 continued to discuss a dislike for chicken with no substitute offered by LPN #5. An interview with Dietary Aide #1, on 02/07/12 at 5:55 PM, revealed she was responsible for ensuring the correct items were placed on the dinner trays, 02/07/12. She revealed she forgot Resident #13 disliked chicken, until the trays were already in the dining room. An interview with the Dietary Manager, on 02/07/12 at 5:50 PM, revealed she expected the dietary aide to ensure all likes and dislikes were honored when preparing the residents trays. She further revealed substitutes were available, if requested by the residents. An interview with the Director of Nursing (DON), on 02/09/12 at 7:15 PM, revealed if a resident voiced a dislike for a certain food, she expected staff to offer a substitute.	F 246		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	**F315** **Resident #1** **1. Corrective Action:** Resident #1 observed for signs and symptoms of a urinary tract infection (UTI). (NASR #1 no longer employed at this facility.)	

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F 315	Continued From page 20 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate catheter care was provided for one resident (#1), in the selected sample of fifteen residents. The facility failed to ensure staff followed the policy for foley catheter care. State Registered Nurse Aide (SRNA) #1 was observed using a soiled cleansing wipe during catheter care. Resident #1 had a history of Urinary Tract Infection (UTI). Findings include: A review of the "Foley Catheter Care" policy/procedure, revised 06/28/11, revealed staff was to cleanse the catheter from the meatus down the catheter about four inches, using soap, water, and a clean washcloth. Repeat, if necessary, using a clean washcloth. A record review revealed Resident #1 was admitted to the facility 03/28/11 with a diagnosis of UTI. A review of the quarterly Minimum Data Set (MDS), dated 11/29/11, revealed the resident was in a Persistent Vegetative State and required total assistance for hygiene. A review of the resident's comprehensive care plans, dated 03/08/11, revealed the resident was at risk for a UTI due to the use of the foley catheter. Interventions included to cleanse thoroughly during peri care, and rinse the area to prevent	F 315	2. ID of Others at Risk All residents requiring a catheter were observed during catheter care by the Corporate Compliance Nurse Trainer on 3-2-12 with no problems identified. 3. Prevention Measures: Catheter and peri care daily checks for proper procedures added to Charge Nurse shift rounds and documented in treatment administration record (TAR). Corporate Nurse Trainer observed nursing staff on 3-3-12 and 3-4-12 completing peri and catheter care. Catheter care reviewed by demonstration techniques on the proper use of a cleansing wipe and the cleansing of the catheter tube during the catheter care. 4. Monitor: Charge Nurse will monitor catheter care during shift rounds. Any problems noted will be corrected immediately and reported to the Director of Nursing or Administrative Nurse. The Special Procedure Review Continuous Quality Improvement Tool will be	

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F 315	Continued From page 21 infection. An observation of catheter care for Resident #1, on 02/08/12 at 8:55 AM, revealed Resident #1 had a large watery bowel movement. SRNA #1 cleansed the resident's peri area with cleansing wipes. She made numerous swipes front to back using the same soiled cleansing wipe. SRNA #1 did not cleanse the resident's catheter tube with a clean cleansing wipe. An interview with SRNA #1, on 02/08/12 at 1:30 PM, revealed she should change the cleansing wipe if visibly soiled with bowel movement. An interview with the Director of Nursing (DON), on 02/09/12 at 7:15 PM, revealed she expected staff to follow the policy for catheter care.	F 315	used by the DON to monitor monthly x 3 months, then quarterly, and reported in the monthly Continuous Quality Improvement (CQI) meeting. **5. Date Correcte:** 3-9-12 **See exhibit #6**	
F 322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies/procedures, it was determined the facility failed to ensure residents received proper treatment and care for gastrostomy tubes for one resident (#6), in the	F 322	**F322** **Resident #6** **1. Corrective Action:** Resident assessed and treated on 1-26-12 by hospital and Primary Physician reviewed on 2-17-12. Licensed staff were inserviced by the DON on 2-10-12 and 3-3-12 to: a. immediately consult with a resident's physician when there is a need to alter treatment for a resident such as the	

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F 322	Continued From page 22 selected sample of fifteen residents, related to complications of the resident's Percutaneous Endoscopic Gastrostomy (peg) tube site. The facility failed to follow their policies/procedures for Enteral Nutrition and Verifying Tube Placement related to gastrostomy tube placement. The facility staff was knowledgeable regarding Resident #6's history of peg tube complications; however, on 01/13/12 and 01/15/12, the facility staff reinserted Resident #6's peg tube without first attaining a physician's order or notifying the physician of the reinsertion. Additionally, on 01/26/12, the facility staff observed at 4:15 AM, yellow drainage coming from the resident's peg tube site. After a period of twelve hours, at 4:15 PM, the facility notified the physician and transferred the resident to hospital #2 after experiencing severe abdominal pain with excessive amounts of greenish/brown drainage coming from the peg tube site. Hospital consultation detailed the resident's peg tube required repositioning due to obstruction. Findings include: A review of the facility's policy/procedure, "Enteral Nutrition - Gastrostomy Tube Placement," revised 10/21/10, revealed the licensed nurse will insert the gastrostomy tube per physician's orders to provide direct access to the stomach for feeding and/or instillation of medicine. A review of the facility's policy/procedure "Verifying Tube Placement," dated 12/13/11, revealed the licensed nurse is responsible for ensuring the tube is positioned in the desired site and for ensuring the tube has remained in the intended position before administering formula or	F 322	reinsertion of a PEG tube or problems with a PEG tube. b. follow the facility Change In Condition Policy c. follow the Enteral Nutrition Policy **2. ID of others at risk:** All residents are at risk for a need to change treatment. DON/ADON and Compliance Nurse reviewed all residents on 3-1-12 and no residents were found to have a need for change in treatment or notification of a physician that had not been contacted appropriately. Only two other residents with a PEG tube in the building. On 3-1-12 the DON reviewed tube fed residents with no needs for change in treatment or need for physician contact noted at present. **3. Prevention measures:** Licensed staff were inserviced by the DON on 2-10-12 and 3-3-12 to immediately consult with a resident's physician when there is a need to alter treatment for a resident, follow the Change In Condition and the Enteral Nutrition Policy. **4. Monitor:** The DON will monitor residents change	

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F 322	Continued From page 23 medications through the tube. Verification of correct tube placement is performed before each intermittent feeding, at least once every twelve hours when continuous feedings are given, and before medications are administered through the tube. A record review revealed the facility admitted Resident #6 on 03/16/09 with diagnoses to include Nausea, Esophageal Reflux, and Gastrostomy. A review of the quarterly Minimum Data Set (MDS), dated 11/23/11, revealed the resident received a tube feeding. A review of the comprehensive care plan, "At Risk for Aspiration related to Tube Feeding, Dysphagia," dated 01/11/12, revealed to monitor the tube feeding site for signs/symptoms of infection, drainage, and excoriation. A review of the Nurse's Notes, dated 01/10/12 at 6:45 AM, revealed the resident's peg tube was dislodged and the physician was notified. A review of the Physician's order, dated 01/10/12, revealed "reinsert peg tube 18 fr [French catheter] with 30 cc [cubic centimeters] balloon under sterile technique." Further review of the Nurse's Notes, dated 01/13/12 at 6:30 AM, revealed "resident's feeding tube dislodged. Re-inserted #16 fr catheter using sterile technique with a 30 cc balloon. Placement checked and verified by two licensed nurses. Resident tolerated well. Denies complaints." Additional record review revealed there was no documented evidence of a physician's order to reinsert the resident's peg tube on 01/13/12. An interview with Registered Nurse (RN) #1, on	F 322	of status utilizing the Resident Status Change –Notification CQI Tool and report findings in the monthly Continuous Quality Improvement (CQI) meeting for three months, then quarterly. **5. Date of Correction:**	3-7-12

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F 322	Continued From page 24 02/08/12 at 7:00 PM, revealed she reinserted a new foley catheter in the resident's peg tube site, on 01/13/12, using clean technique. She stated there was no way to keep it sterile. Furthermore, RN #1 revealed she did not notify the physician regarding the reinsertion of the peg tube. A review of the Nurse's Notes, dated 01/15/12 at 8:30 AM, revealed "while doing A.M. flush, peg tube came out. Placement was verified before and it was flushing slower at the time it came out/dislodged. Reinserted #18 fr catheter using 30 cc normal saline. Resident was in slight discomfort during, but no irritation after. Placement verified upon insertion by two licensed nurses. Flushing well and no discomfort voiced at this time. No adverse side effects related to Vitamin D for Vitamin D deficiency observed." Further record review revealed there was no evidence of a physician's order to reinsert the resident's peg tube on 01/15/12. An interview with Licensed Practical Nurse (LPN) #3, on 02/09/12 at 10:40 AM, revealed she was the resident's nurse, on 01/15/12. The resident's peg tube was dislodged while administering medications, and she informed RN #1, who reinserted the peg tube. Placement of the peg tube was verified by both RN #1 and LPN #3. LPN #3 revealed the physician was not notified about the reinsertion of the peg tube, because it was her understanding that the initial physician's order, written on 01/10/12, meant to replace the peg tube as needed. An interview with Resident #6's Primary Physician, on 02/08/12 at 2:45 PM, revealed she expected the nursing staff to notify her each time the resident's peg tube became dislodged.	F 322		

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F 322	Continued From page 25 An interview with the Director of Nursing (DON), on 02/09/12 at 7:15 PM, revealed she expected the nurse to reinsert the peg tube to ensure the resident's site did not close; however, the physician should have been notified promptly. Further review of the Nurse's Notes, dated 01/17/12 at 9:17 AM, revealed an "appointment at [hospital #1] Endoscopy to replace peg tube at 2:00 PM today." Additional review revealed the ambulance was to arrive at the facility, at 1:15 PM, to transport the resident to hospital #1. A review of the Nurse's Notes, dated 01/25/12 at 8:00 AM, revealed "abdomen soft, round and non-distended upon palpation. Bowel sounds present [times] four quadrants. Clear fluid seeping from peg site, complaint of headache and nausea," "complaint of tenderness in abdomen near peg," "will call to set up ambulance for treatment per MD orders." A review of the Nurse's Notes, dated 01/25/12 at 8:10 AM, revealed "spoke with Endoscopy - prepared to see resident at 9:00 AM," "resident continues to be NPO [nothing by mouth] with no use of peg per MD orders." A review of the Nurse's Notes, dated 01/25/12 at 8:40 AM, revealed the resident was transported to hospital #1 via ambulance for an endoscopy procedure, and at 12:45 PM, Resident #6 returned to the facility after being examined by the endoscopy department (at hospital #1) related to peg tube complications. It was determined by endoscopy the resident's peg tube was functioning properly and orders were resumed. A review of the Nurse's Notes, dated 01/26/12 at 4:15 AM, revealed the resident's peg tube was assessed at that time with a moderate amount of yellow	F 322		

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F 322	Continued From page 26	F 322		

drainage noted around the tube. There was no documented evidence of physician notification.
An interview with RN #1, on 02/08/12 at 7:00 PM, revealed, on 01/26/12 at 4:15 AM, there was drainage around the resident's peg tube with a slow leakage, but not "major drainage." She revealed drainage was not "normal," but the resident had a history of complications from the peg tube. She revealed the physician was not notified regarding the peg tube drainage.
Additional record review revealed, on 01/26/12 at 4:15 PM, the resident was in severe abdominal pain with excessive amounts of greenish/brown drainage around the peg tube site. On 01/26/12 at 4:30 PM, the physician was notified. On 01/26/12 at approximately 5:40 PM, the resident was transported to the emergency room per ambulance, and was admitted to hospital #2 with peg tube complications. A review of the Consultation report, dated 01/27/12, revealed treatment during hospitalization consisted of repositioning of the peg tube due to obstruction.

An interview with the DON, on 02/09/12 at 7:15 PM, revealed the physician should have been notified about the drainage around the resident's peg tube, on 01/26/12 at 4:15 AM.

An interview with Resident #6's Primary Physician (#1), on 02/08/12 at 2:45 PM, revealed she should have been notified about the moderate yellow drainage, on 01/26/12 at 4:15 AM, as she would have sent the resident to the emergency room at that time.

An interview with Physician #2, on 02/26/12 at 4:00 PM, revealed when he examined the resident in hospital #2's intensive care unit (ICU),

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F 322	Continued From page 27 the resident was not communicating and appeared sleepy and confused. He stated while he was uncertain about the resident's pain level at that time, the resident had cellulitis (or redness) around the peg tube site which could be indicative of an infection at the site, and the blockage of the stomach content (or stomach acid) could have contributed to the discharge at the site.	F 322		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#4), in the selected sample of fifteen residents, received adequate supervision to prevent accidents. On 09/14/11, Resident #4, who the facility had assessed and identified as having a history of sexually inappropriate behaviors, was observed naked in the bed with his/her roommate (Resident #21) "humping" on him/her. Resident #4 was unclothed and there was no cover separating him/her from Resident #21. Resident #21 was observed with his/her hipsters on and was laying in bed with his /her	F 323	**F323** **Resident #4** **1. Corrective action:** Resident #4 placed on one to one supervision February 10, 2012. Inservice on the supervision of residents to provide protection in the facility after an allegation of abuse was provided for the Administrator by the Corporate Compliance Nurse and then for supervisory staff including Charge Nurses, Administrative Nurses (DON, ADON, Compliance Nurse), and Department Leaders on February 10, 2012. *Supervision of residents for safety after an allegation of abuse as well as the supervision to assist in the prevention of abuse* was presented to the group by the Corporate Compliance Nurse and the Administrator. Examples were provided by the Corporate Compliance Nurse as how to separate and protect a resident that had been involved in an altercation or other compromising situation. Any remaining supervisory persons not in attendance are being required to be inserviced on same topic by the Administrator,	

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F 323	Continued From page 28 eyes closed. SRNA #2 intervened and the resident returned to his/her bed. Registered Nurse (RN) #2 was informed about the incident and she notified the Assistant Director of Nursing (ADON). RN #2 started every fifteen (15) minute checks on Resident #4. There was no evidence the facility followed their "Abuse" policy/procedure to ensure the resident's safety and protection was first assured and the residents were separated, as the State Registered Nurse Aide (SRNA) and the Certified Medication Technician (CMT) left both Resident #4 and Resident #21 alone in the room together. The facility only initiated every fifteen minute checks, thus leaving the perpetrator (Resident #4) access to Resident #21 and all residents of the unit without supervision. Furthermore, the facility implemented pharmacological interventions to reduce sexual desire even though the psychiatrist had determined this drug ineffective. Additionally, the facility's investigation failed to identify Resident #4's behavior on 09/14/11 as an allegation of abuse and failed to determine that the resident's actions were of sexual nature which prevented the facility from taking actions to protect residents from abuse. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Based on interview and record review, it was determined Immediate Jeopardy was identified on 02/10/12 and determined to exist on 09/14/11 through 02/13/12. An acceptable Allegation of Compliance (AoC) was received on 02/13/12. Immediate Jeopardy was removed, effective 02/14/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the	F 323	DON or Administrative Nurses on an individual basis prior to their next shift. Inservice was held on this date, February 10, 2012, for all Charge Nurses, Administrative Nurses, Social Services Director, Administrator, and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report. The initial inservice was provided by the Corporate Compliance Nurse with any remaining persons being inserviced by the Administrator, DON or Administrative Nurses on an individual basis prior to their next shift. Corporate Compliance Nurse trained administrator that all alleged violations involving mistreatment, neglect or abuse (specific to F225) must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is	

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F 323	Continued From page 29 implementation of changes and quality assurance activities. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F225 and F490) Findings include: A review of the facility's policy/procedure, "Resident Abuse, Neglect and Exploitation" dated 04/12/10, revealed it is the goal of the facility to have a process in place to protect the health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation an injuries of unknown origin. If a resident to resident altercation occurs, the resident's safety and protection will first be assured. The residents shall be separated from each other and the families and physician shall be notified. An investigation will be performed to determine if abuse has occurred. If it is determined that abuse has occurred, an evaluation of the abusing resident shall be completed to determine if there is a problem that would require medical intervention. The incident will be viewed as a reportable incident with proper protocol followed and the appropriate agencies will be notified. A record review revealed Resident #4 was admitted to the facility on 01/02/02 with diagnoses to include Late of Effects of Fracture of Skull and Face Bones, Intermittent Explosive Disorder, Depressive Disorder and Senile Dementia. A review of the quarterly Minimum Data Set (MDS), dated 12/22/11, revealed the resident was severely cognitively impaired and rarely made	F 323	sufficient and adequate investigation and reporting. Investigation and reporting information along with supervision information was relayed to the Charge Nurses, Administrative Nurses, Social Services Director and Department Leaders by the Administrator after being inserviced by the Corporate Compliance Nurse. To ensure that the environment remains as free of accident hazards as is possible and in compliance with F323, compliance rounds have been established 2 times per shift to be completed by the Charge Nurses to ensure adequate care and supervision is being provided for the residents by the Nurse aides and a safe environment free from accident hazards (including abuse) is being maintained. Any problems will be addressed immediately and a report provided to the DON of every round. Nurse aide rounds are being established this date every hour to view residents frequently, know their whereabouts, assure that the environment remains free of accident hazards (including looking for any signs pertaining to abuse or any hazard condusive to abuse) and assure that a safe environment is being maintained. Charge Nurses are training Nurse Aides at the beginning of each shift beginning on evening shift 2-10-12. **2. ID of Others at Risk:** All residents are considered to	

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F 323	Continued From page 30 decisions. A review of the Mood and Behavior Patterns, dated 09/11, revealed staff documented on 09/01/11, 09/08/11, 09/14/11 (6 AM-2 PM shift and 2 PM-10 PM shift), 09/17/11, and 09/22/11, that Resident #4 displayed inappropriate sexual behavior. An interview with Licensed Practical Nurse (LPN) #6, on 02/10/12 at 9:38 AM, revealed Resident #4 would frequently try to put his/her arm around staff and if he/she had stayed up late during the night, he/she might ask the staff to give him/her a kiss. Resident #4 at times would be aware of what he/she was doing and other times he/she would not. The staff would redirect the resident when the behavior was displayed. She had observed Resident #4 sitting on the bed of Resident #21 in the past. Resident #4 was sitting at the foot of the bed and Resident #21 would be in the bed lying at the top. The staff would redirect Resident #4 and help him/her get back to his/her bed. An interview with the psychiatrist, on 02/13/12 at 11:22 AM, revealed he was familiar with Resident #4 since admission to the facility and had treated him/her afterwards. Resident #4 had documented episodes of walking into the dayroom of the facility naked in full view of female residents and visitors in the room. There were also documented episodes of the resident asking other residents and visitors sexually inappropriate questions in 5/4/10. The resident had a history of alcoholism and he had learned these resident's didn't sensor their behavior and acted on impulse. The resident had cognitive deficits and had previously been on Depo-Provera injections for sexually inappropriate behavior. The injections	F 323	be at risk although resident #4 is unsteady on their feet and ambulation is self-limited. All residents assessed by Licensed Nursing Staff utilizing observation and interview. (See Residents at Risk for Abuse Assessment form) In an effort to reduce risk to residents, the Corporate Compliance Nurse is to be notified of any allegation of abuse immediately of the incident along with proper reporting to DCBS and OIG. All resident incident reports are reviewed in regularly scheduled Morning Staff Meetings M-F. Any incident reports containing allegations of abuse will be forwarded to the Concord Health Systems Corporate Office for review by the Corporate Compliance Nurse to assure that protection of the resident, investigation and reporting have been accomplished correctly. **3. Prevention measures:** Inservice on the supervision of residents to provide protection in the facility after an allegation of abuse was provided for the Administrator by the Corporate Compliance Nurse and then for supervisory staff including Charge Nurses, Administrative Nurses, and Department Leaders on February 10, 2012.	

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F 323	Continued From page 31 were discontinued in July 2011 related to not seeing any effectiveness of the medication. At the time he completed a review of his/her medications, he was urged to reduce the number of medications the resident was taking. He revealed those medications identified as not helping Resident #4 were discontinued. There was clear evidence of sexually inappropriate behavior and some type of intervention was warranted to reduce or minimize the sexually inappropriate behavior. The staff would call and a medication was prescribed; however, the staff would call back stating the resident was lethargic and having increased falls. He revealed the staff were his eyes and ears but he was not aware Resident #4 was started back on the Depo-Provera injections for sexual aggression. A review of the nurse's notes, dated 09/14/11 at 10:00 PM, and an interview with SRNA #2, on 02/09/12 at 5:10 PM, revealed she observed Resident #4 "humping" on his/her roommate (Resident #21). Resident #4 was laying in the bed behind the roommate without any clothes on and the roommate was wearing a pair of hipsters. There was no blanket between the residents and he/she was "humping" on the roommate. SRNA #2 called the resident's name and asked what he/she was doing. Resident #4 got up from the victim's bed, ambulated back to his/her bed and got dressed again. She left the room and the residents were left unsupervised. SRNA #2 reported the incident to the charge nurse on duty (RN #2). Registered Nurse (RN) #2 documented an SRNA reported to her she witnessed Resident #4 naked and in the bed with the roommate "humping" up on him/her. The roommate was dressed and under the covers with his/her eyes	F 323	Supervision of residents for safety after an allegation of abuse as well as the supervision to assist in the prevention of abuse was presented to the group by the Corporate Compliance Nurse and the Administrator. Any remaining supervisory persons not in attendance is being required to be inserviced on same topic by the Administrator, DON or Administrative Nurses (ADON or Compliance Nurse) on an individual basis prior to their next shift. Inservice was held on this date, February 10, 2012, for all Charge Nurses, Administrative Nurses, Social Services Director, Administrator, and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report. The initial inservice was provided by the Corporate Compliance Nurse with any remaining persons being inserviced by the Administrator, DON or Administrative Nurses on an individual basis prior to their next shift.	

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F 323	Continued From page 32 closed. Resident #4 was redirected and dressed. She could not recall for certain if she had received reports of Resident #4 getting into bed with other residents but it was common knowledge. The Assistant Director of Nursing (ADON) was notified and advised to place the resident on every fifteen (15) minute checks for safety. Staff was directed to check on Resident #4 every fifteen (15) minutes. Additionally, she reported staff caught the resident in bed with other residents in the past, but he/she was not "humping" on them. The staff redirected Resident #4 and he/she got up from the bed. The resident cursed at the staff but he/she was compliant. The staff has caught the resident in the bed with a resident of the same gender. The staff intervened with redirection and they documented the behavior continued with no other approach implemented. During the month of 10/11, staff documented one incident on the 12th of the resident displaying inappropriate sexual behavior. The staff responded with redirection and it was effective. During the month of 11/11, staff documented on the 16th, 18th and 23rd Resident #4 displayed inappropriate sexual behavior. The staff responded with redirection; however, they documented the behavior continued with no other approach implemented. During the month of 12/11, staff documented on the 5th and 6th Resident #4 displayed inappropriate sexual behavior. The staff intervened with redirection and they documented the behavior continued with no other interventions implemented. An interview with Certified Medication Technician (CMT) #1 on 02/9/12 at 6:14 PM and 2/10/12 at 10:21 AM, revealed she and an aide walked into	F 323	Corporate Compliance Nurse trained administrator that all alleged violations involving mistreatment, neglect or abuse (specific to F225) must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting. Investigation and reporting information along with supervision information was relayed to the Charge Nurses, Administrative Nurses, Social Services Director and Department Leaders by the Administrator after being inserviced by the Corporate Compliance Nurse. To ensure that the environment remains as free of accident hazards as is possible and in compliance with F323, compliance rounds have been established 2 times per shift to be completed by the Charge Nurses to ensure adequate care and supervision is being provided for the residents by the Nurse aides and a safe environment free from accident hazards (including abuse) is being maintained. Any problems will be addressed immediately and a report provided to the DON of every round. Nurse aide rounds are being established this date every hour to view residents frequently, know their whereabouts, assure that the environment remains	

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F 323	Continued From page 33 the room and observed Resident #4 trying to perform a sex act with his/her roommate (Resident #21). Resident #4 acted like he/she was trying to have sex with the roommate (Resident #21). The room was dark and she was unable to recall if Resident #4 had clothes on or if there were covers between the residents. They intervened, she guided Resident #4 back to his/her bed and left the room. SRNA #2 informed the charge nurse and the CMT documented the behavior on the resident's behavior sheet. An interview with Registered Nurse (RN) #2, on 02/09/12 at 5:56 PM, revealed SRNA #2 reported to her Resident #4 was observed "humping" on his/her roommate (Resident #21). RN #2 checked both of the residents and did not observe any injury. They were told by other staff on the other shifts to keep an eye on him/her. She notified the ADON and was advised to put Resident #4 on every 15 minute checks. A review of the close observation or 1:1 supervision revealed every 15 minute checks were initiated on 09/14/11 at 10:00 PM and discontinued on 09/17/11 at 6:45 AM. The facility initiated close observations on 09/14/11 but did not separate Resident #4 and Resident #21 per their policy. Staff did not implement any other monitoring of the resident except for the routine checks and staff documented Resident #4 displayed sexually inappropriate behavior during October, November and December of 2011. An interview with Resident #4's primary care physician, on 02/13/12 at 10:57 AM, revealed he was informed the incident on 09/14/11 was not sexual in nature. The ADON informed him the	F 323	free of accident hazards (including looking for any signs pertaining to abuse or any hazard condusive to abuse) and assure that a safe environment is being maintained. Charge Nurses are training Nurse Aides at the beginning of each shift beginning on evening shift 2-10-12. **4. Monitor:** Daily monitoring of incident reports that include investigation and supervision information days per week for three months. Any problems will be reported immediately to Corporate Compliance Nurse for action. **5. Date Corrected:**	2-15-12

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resident was confused and got into the wrong bed. It was documented in the resident's history of sexually aggressive behavior but he was not aware of any sexually inappropriate behaviors. Resident #4 was demented and was unsure if he/she knew what they were doing.

A review of the medication administration record (MAR), dated September 2011, revealed on 09/16/11, Depo-Provera 150 milligrams (mg) was administered via intramuscular (IM) injection by RN #2.

An interview with the DON, on 02/09/11 at 7:41 PM, revealed she received the report of the incident the next morning (09/15/11) in their daily meeting with the department heads. She stated the incident was reported to the ADON and she advised the staff to put Resident #4 on every fifteen (15) minute checks. The resident continued to be monitored by the staff and behaviors were recorded on his/her Behavior Observation/Mood and Behavior Pattern.

An interview with the Administrator, on 02/09/12 at 8:10 PM, revealed she was the Abuse Coordinator and completed the investigations in the facility; however, she did not complete the investigation for the incident on 09/14/11 involving Resident #4. The DON completed the investigation. The team determined there was no abuse identified because Resident #4 was confused and he/she was trying to get in the bed and detailed there was nothing sexual in nature about the incident, despite the observations made by SRNA #2 and CMT #1 both reporting that Resident #4 was "humping" Resident #21 and trying to perform a sexual act. The Administrator

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maintained that Resident #4 was not trying to attack the other residents and did not put the other residents at risk, but rather he/she was trying to get in a bed. He/she thought it was his/her bed but as a precaution staff put Resident #4 on extra supervision. While the 15 minute checks were initiated for staff to check on Resident #4, it would be possible in those other 14 minutes for the resident to get up and get in bed with a resident but the staff would have responded to the alarms as well. The Administrator stated she had no problem with the investigation determination.

An acceptable Allegation of Compliance was received on 02/13/12 and detailed the following:

On 02/10/12, the Administrator was trained by the Corporate Compliance Nurse that all alleged violation involving mistreatment, neglect, or abuse (specific F225) must be reported to other officials such as the Department of Community Based Services (DCBS) and Office of Inspector General (OIG). There must be evidence that all alleged violation are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting.

On 02/10/12, all Charge Nurses, Administrative Nurses, Social Services Director, Administrator and Department Leaders was inserviced on the Abuse, Neglect and Exploitation Policy. Additionally, nurse aide rounds were established and conducted every hour to view the residents, know their whereabouts and assure their environment was free of accident hazards.

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F 323	Continued From page 37 reported to the other officials. A review of the nurse aide rounds sheets revealed the residents within the facility were monitored hourly and documented they had checked on each residents. Each CNA revealed they had been trained by the Charge Nurses about conducting the hourly rounds. Interview with Licensed Staff and aides, on 02/13/12, revealed they had received inservicing on 02/10/12 related to abuse, separating the residents, placing the aggressor on one to one supervision and notifying the Administrative Nurse on-call. Additionally, the nurses would start the investigation and get statements from all staff working at the time of the incident. They would also interview the residents to see if they had any knowledge of the incident. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Based on interview and record review, it was determined Immediate Jeopardy was identified on 02/10/12 and determined to exist on 09/14/11 through 02/13/12. An acceptable Allegation of Compliance (AoC) was received on 02/13/12. Immediate Jeopardy was removed, effective 02/14/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F225 and F490)	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	**F371** **1. Corrective Action:** On 2-10-12, the Administrator counseled Dietary Aide #2 on	

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F 371	Continued From page 38 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy/procedure, it was determined the facility failed to prepare, distribute, store and serve food under sanitary conditions during the tray line service on 02/07/12 at 11:00 AM through 12:15 PM. The facility failed to ensure staff restrained their hair and followed sanitary practices during the preparation, distribution and meal service. Findings include: A review of the facility's policy/procedure, "Personnel Adherence to Sanitary Procedure," undated, revealed food services and dietary personnel will be required to adhere to the following sanitary standards: (1) hair nets or approved hats, covering all of the hair, must be worn at all times while on duty. (2) If gloves are used in food preparation, food services and dietary personnel will wash hands before donning gloves, If a task is interrupted, gloves will be removed and clean gloves donned when the task is resumed.	F 371	covering all hair with a hair bonnet and Dietary Aide #2 restrained all of her hair under the bonnet. On 2-7-12, the Administrator Counseled the Cook on removing Her gloves after leaving the Tray line each time and Washing her hands before returning To the tray line. On 2-7-12, the Administrator Counseled the cook on changing Her gloves and washing her Hands prior to returning to The buffet table. **2. ID of Other Residents at Risk:** All residents are at risk from improper sanitation and food service/handling practices. **3. Preventative Measures:** Dietary employees, including Dietary Aide #2 and the Cook, Will be inserviced by the Corporate Registered Dietitian on 3-1-12 on the facility's policy and procedure on "Personnel Adherence to Sanitary Procedure" to ensure that: a. hair nets or approved hats, covering all of the hair, must be worn at all times while on duty;	

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F 371	Continued From page 39 1. An observation, on 02/07/12 at 8:00 AM and 11:00 AM, revealed Dietary Aide #2's hair was not restrained with a hair bonnet. Additionally, all hair is suppose to be restrained under the hair bonnet. An interview with Dietary Aide #2, on 02/08/12 at 9:05 AM, revealed when she was in the kitchen, she knew her hair was suppose to be completely restrained. She stated she was in a hurry the previous day and forgot to place the hair net over the front of her hair. 2. An observation, at 11:20 AM and 11:28 AM, revealed the Cook left the tray line area, picked up the telephone receiver and made an announcement that the trays were ready. The Cook did not remove her gloves after leaving the tray line each time and she did not wash her hands before returning to the tray line. 3. An observation, at 12:05 PM, revealed the Cook removed an empty pan which contained meatloaf, pressed the code on the key pad to the kitchen, and picked up another pan of meatloaf in the kitchen, without changing her gloves or washing her hands and returning to the buffet table. An interview with the Cook, on 02/09/12 at 10:40 AM, revealed anytime staff left the tray line, they were expected to wash their hands and put on a new pair gloves upon return. She realized she did not do that each time she left the tray line and stated she was a little nervous. An interview with the Dietary Manager, on 02/07/12 at 5:35 PM, revealed the cook was not	F 371	b. if gloves are used in food preparation, food services and dietary personnel will wash hands before donning gloves. If a task is interrupted, gloves will be removed and clean gloves donned when the task is resumed. All newly hired dietary staff will receive the same education during the orientation process. **4. Monitor:** A Dietary Sanitation Audit will be completed by the Food Service Manager monthly to to ensure proper use of hair bonnets to fully cover hair and to ensure infection control practices for the donning of gloves is followed. The results of these audits will be reported monthly to the Quality Assurance Committee for review and further recommendations if needed. The Quality Assurance Committee meetings occur monthly and include the Administrator, Director of Nursing, Department Managers, and the Medical Director. **5. Corrective Date:** **See exhibits #7a-7b; 1, and 12a-12f**	3-2-12

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F 371	Continued From page 40 suppose to leave the tray line when they were serving. She was usually in the kitchen when the carts were ready to be sent out to the floor and she announced it; however, she was not in the kitchen earlier when the lunch carts were ready for pick-up. Additionally, all hair is suppose to be restrained under the hair bonnet.	F 371	**F441** **1. Corrective Action:** On 2-16-12, the Director of Nursing provided LPN #1 in-service training on infection control/universal precautions for removal of soiled loves and washing of hands between tasks to prevent cross contamination. Following the inservice given by the Director of Nursing, the Assistant Director of Nursing and Compliance Nurse conducted a check off for skill proficiency of LPN #1 on infection control/universal precautions for removal of soiled gloves and washing of hands between tasks to prevent cross contamination with LPN #1 showing proficiency. **2. ID of Other Residents at Risk:** All residents are at risk for cross contamination from improper infection control techniques. All residents with a requirement of treatment provided only by licensed staff were reviewed on 3-4-12 by the Corporate Nurse Educator with no problems identified.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		

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F 441	Continued From page 41 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure staff washed their hands and changed gloves as indicated by accepted professional practice. The facility staff failed to follow the facility's Infection Control policy. On 02/08/12, Licensed Practical Nurse (LPN) #1 did not remove soiled gloves and wash her hands between tasks to prevent cross contamination. Findings include: A review of the facility's policy/procedure, "Infection Control, Universal Precautions," revised 03/09/10, revealed gloves should be changed between tasks and procedures on the same resident after contact with material that may have contained a high concentration of microorganisms. Hands should be washed between tasks and procedures on the same resident to prevent cross-contamination of different body sites. An observation of a treatment, on 02/08/12 at 7:55 AM, revealed LPN #1 cleansed a resident's	F 441	**3. Preventative Measures:** On 2-16-12, the Director of Nursing provided re-education, competency skills and monitoring to licensed nurses. The Corporate Nurse Educator will provide additional orientation and training upon hire and annually thereafter to ensure that all licensed nurses are knowledgeable in the area of Infection Control and Universal Precautions. The Corporate Nurse Educator will also provide annual competency skills training in hand washing techniques and donning of gloves during clinical nursing procedures beginning 2-29-12. 4. The LPN Corporate Nurse Educator will provide random monitoring weekly for three months to observe licensed nurses for proper hand washing techniques and donning of gloves during clinical nursing procedures. Results of the random audits will be reviewed weekly by the facility interdisciplinary team. The Interdisciplinary Teem meetings include the Administrator, Director of Nursing, and Department Managers. The Director of Nursing will submit a monthly report to the facility Quality Assurance Committee where results will be	

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F 441	Continued From page 42 Percutaneous Endoscopic Gastrostomy (peg) tube site with guaze and applied a moisture barrier cream to the site. She then put her stethoscope in her ears to check placement of the resident's peg tube, in preparation to administer medications; however, she did not remove her soiled gloves or wash her hands between tasks. An interview with LPN #1, on 02/08/12 at 4:22 PM and on 02/09/12 at 4:00 PM, revealed she would not have changed her gloves or washed her hands between the peg tube dressing change and giving the resident's medications through the peg tube, as both tasks involved the same area (the peg tube). An observation of a treatment, on 02/08/12 at 8:35 AM, revealed LPN #1 cleansed a moderate amount of yellow/green sputum from around a resident's tracheostomy with gauze. She then prepared and administered a nebulizer treatment to the resident; however, she did not remove her soiled gloves or wash her hands between tasks. An interview with LPN #1, on 02/08/12 at 4:22 PM and 02/09/12 at 4:00 PM, revealed she should have removed her gloves and washed her hands before administration of the nebulizer treatment. An interview with the Director of Nursing (DON), on 02/09/12 at 7:15 PM, revealed she expected the staff to change their gloves and wash their hands between tasks on the same resident.	F 441	reviewed and interventions monitored. The facility Quality Assurance Committee includes the Administrator, Director of Nursing, Department Managers, and Medical Director. **5. Completion Date:**	3-5-12
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that	F 490	**F490** **Resident #4** **1. Corrective Action:** Resident #4 placed on one to one supervision February 10, 2012.	

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F 490	Continued From page 43 enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to be administered in a manner that enabled it to use it resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident (#4) in the selected sample of fifteen residents. The facility failed to thoroughly investigate an allegation of abuse which prevented the facility from taking appropriate action to protect the other residents from further abuse. On 09/14/11, Resident #4 was observed unclothed in the bed of his/her roommate (Resident #21) "humping" on him/her. There were no covers between the residents and Resident #21 was asleep. State Registered Nurse Aide (SRNA) #2 and Certified Medication Technician (CMT) #1 called Resident #4's name and he/she got up from the roommate's bed, redressed and returned to bed. SRNA #2 and CMT #1 left the room and left the residents unsupervised while it was reported to the charge nurse. The Administrator's failure to administer the facility in a manner that enabled it to use its resources to ensure policy and procedures were	F 490	Corporate Compliance Nurse re-educated Administrator on this date 2-10-12, regarding the reporting of incidents and the management of the facility to provide the highest, practicable physical, mental and psycho-social well being for each resident by utilizing information from the Long Term Care Survey manual. The Administrator is to ensure there is sufficient and adequate investigation and reporting. Corporate Compliance Nurse trained administrator that all alleged violations involving mistreatment, neglect or abuse (specific to F225) must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report. **2. ID of Others at Risk:** All residents are considered to be at risk although resident #4 is unsteady on their feet and ambulation is self-limited. All residents assessed by Licensed	

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F 490	Continued From page 44 implemented to ensure allegations of abuse were thoroughly investigated, provide supervision to protect the residents and report the results of the investigation to the appropriate agencies, caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was determined to exist on 09/14/11. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/10/12 and determined to exist on 09/14/11 through 02/13/12. An acceptable Allegation of Compliance (AoC) was received on 02/13/12. Immediate Jeopardy was removed, effective 02/14/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F225 and F323) Findings include: A review of the facility's policy and procedure, "Resident Abuse, Neglect and Exploitation," dated 04/12/10, revealed it is the goal of the facility to have a process in place to protect the health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation and injuries of unknown origin. If a resident to resident altercation occurs, the resident's safety and protection will first be assured. The residents shall be separated from each other and the	F 490	Nursing Staff utilizing observation and interview. (See Residents at Risk for Abuse Assessment form) In an effort to reduce risk to residents, the Corporate Compliance Nurse is to be notified of any allegation of abuse immediately of the incident along with proper reporting to DCBS and OIG. All resident incident reports are reviewed in regularly scheduled Morning Staff Meetings M-F. Any incident reports containing allegations of abuse will be forwarded to the Concord Health Systems Corporate Office for review by the Corporate Compliance Nurse to assure that protection of the resident, investigation and reporting have been accomplished correctly. **3. Prevention Measures:** Corporate Compliance Nurse re-educated Administrator on this date 2-10-12 regarding the reporting of incidents and the management of the facility to provide the highest, practicable physical, mental and psycho-social well being. The Administrator is to ensure there is sufficient and adequate investigation and reporting. Corporate Compliance Nurse trained administrator that all alleged violations involving mistreatment, neglect or abuse (specific to F225) must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are	

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F 490	Continued From page 45 families and physician shall be notified. An investigation will be performed to determine if abuse has occurred. If it is determined that abuse has occurred, an evaluation of the abusing resident shall be completed to determine if there is a problem that would require medical intervention. The incident will be viewed as a reportable incident with proper protocol followed and the appropriate agencies will be notified. A record review revealed Resident #4 was admitted to the facility on 01/02/02 with diagnoses to include Late of Effects of Fracture of Skull and Face Bones, Intermittent Explosive Disorder, Depressive Disorder and Senile Dementia. A review of the quarterly Minimum Data Set (MDS), dated 12/22/11, revealed the resident was severely cognitively impaired and rarely made decisions. A review of the Mood and Behavior Patterns, dated 09/11, revealed staff documented on 09/01/11, 09/08/11, 09/14/11 (6 AM-2 PM shift and 2 PM-10 PM shift), 09/17/11, and 09/22/11, that Resident #4 displayed inappropriate sexual behavior. An interview with the psychiatrist, on 02/13/12 at 11:22 AM, revealed he was familiar with Resident #4 since admission to the facility and had treated him/her afterwards. Resident #4 had documented episodes of walking into the dayroom of the facility naked in full view of female residents and visitors in the room. There were also documented episodes of the resident asking other residents and visitors sexually inappropriate questions in 5/4/10. The resident had a history of alcoholism and he had learned these resident's didn't sensor their behavior and acted on impulse. The resident had cognitive deficits and had	F 490	thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report. Corporate Compliance Nurse to visit on a weekly basis to follow up on Administrative practices **4. Monitor:** Corporate Compliance Nurse to visit on a weekly basis to follow up on Administrative practices. Progress will be reported in the monthly Corporate Quality Assurance staff meetings via the Compliance Nurse monthly report and any compromising issues will handled immediately. **5. Date Corrected:**	2-15-12

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F 490	Continued From page 46	F 490		

previously been on Depo-Provera injections for sexually inappropriate behavior. The injections were discontinued in July 2011 related to not seeing any effectiveness of the medication. At the time he completed a review of his/her medications, he was urged to reduce the number of medications the resident was taking. He revealed those medications identified as not helping Resident #4 were discontinued. There was clear evidence of sexually inappropriate behavior and some type of intervention was warranted to reduce or minimize the sexually inappropriate behavior. The staff would call and a medication was prescribed; however, the staff would call back stating the resident was lethargic and having increased falls. He revealed the staff were his eyes and ears but he was not aware Resident #4 was started back on the Depo-Provera injections for sexual aggression.

A review of the nurse's notes, dated 09/14/11 at 10:00 PM, and an interview with SRNA #2, on 02/09/12 at 5:10 PM, revealed she observed Resident #4 "humping" on his/her roommate (Resident #21). Resident #4 was laying in the bed behind the roommate without any clothes on and the roommate was wearing a pair of hipsters. There was no blanket between the residents and he/she was "humping" on the roommate. SRNA #2 called the resident's name and asked what he/she was doing. Resident #4 got up from the victim's bed, ambulated back to his/her bed and got dressed again. She left the room and the residents were left unsupervised. SRNA #2 reported the incident to the charge nurse on duty (RN #2). Registered Nurse (RN) #2 documented an SRNA reported to her she witnessed Resident #4 naked and in the bed with the roommate

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F 490	Continued From page 47 "humping" up on him/her. The roommate was dressed and under the covers with his/her eyes closed. Resident #4 was redirected and dressed. She could not recall for certain if she had received reports of Resident #4 getting into bed with other residents but it was common knowledge. The Assistant Director of Nursing (ADON) was notified and advised to place the resident on every fifteen (15) minute checks for safety. Staff was directed to check on Resident #4 every fifteen (15) minutes. Additionally, she reported staff caught the resident in bed with other residents in the past, but he/she was not "humping" on them. The staff redirected Resident #4 and he/she got up from the bed. The resident cursed at the staff but he/she was compliant. The staff has caught the resident in the bed with a resident of the same gender. The staff intervened with redirection and they documented the behavior continued with no other approach implemented. During the month of 10/11, staff documented one incident on the 12th of the resident displaying inappropriate sexual behavior. The staff responded with redirection and it was effective. During the month of 11/11, staff documented on the 16th, 18th and 23rd Resident #4 displayed inappropriate sexual behavior. The staff responded with redirection; however, they documented the behavior continued with no other approach implemented. During the month of 12/11, staff documented on the 5th and 6th Resident #4 displayed inappropriate sexual behavior. The staff intervened with redirection and they documented the behavior continued with no other interventions implemented. An interview with Certified Medication Technician	F 490		

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F 490	Continued From page 48	F 490		

(CMT) #1 on 02/9/12 at 6:14 PM and 2/10/12 at 10:21 AM, revealed she and an aide walked into the room and observed Resident #4 trying to perform a sex act with his/her roommate (Resident #21). Resident #4 acted like he/she was trying to have sex with the roommate (Resident #21). The room was dark and she was unable to recall if Resident #4 had clothes on or if there were covers between the residents. They intervened, she guided Resident #4 back to his/her bed and left the room. SRNA #2 informed the charge nurse and the CMT documented the behavior on the resident's behavior sheet.

An interview with the Director of Nursing (DON), on 02/10/12 at 1:24 PM, revealed she completed the investigation of the incident on 09/14/11 involving Resident #4 and his/her roommate (Resident #21). She revealed there was one witness to the incident and she did not interview any cognitively intact residents or staff. She determined, along with the department heads in their daily meeting, the resident was confused and got in the wrong bed.

An interview with the Administrator, on 02/09/12 at 8:10 PM, 02/10/12 at 1:15 PM, and 02/13/12 at 8:30 AM, revealed she was responsible for the operation of the facility. She revealed the incident that occurred on 09/14/11 was discussed by the team the next day in the morning meeting. The staff moved Resident #4 back to his/her bed and they put him/her on 15 minute checks. The facility determined the resident thought it was his/her bed but as a precaution, they put him/her on extra supervision. She usually did the investigations in the facility and would interview staff as well as other residents related to the incident; however,

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F 490	Continued From page 49 she found no concerns with this investigation completed by the DON, who did not conduct interviews with other staff or residents and despite the resident's history of sexually inappropriate behaviors and two staff alleging Resident #4 was "humping" and trying to perform a sexual act, determined it was not sexual in nature. The facility maintained Resident #4 was confused and the movement was related to him/her trying to get in the bed. If she would have determined there was abuse then she would have certainly contacted all the appropriate agencies, but it was not identified. A review of the record revealed the facility initiated fifteen minute checks on 09/14/11 at 10:00 PM. On 09/16/11, the facility administered Depo Provera to reduce sexual desire even though their investigation determined the resident's movement was just trying to get into the bed. Furthermore, this intervention had been determined ineffective for this resident in July 2011 by the psychiatrist. The facility discontinued every fifteen minute checks on 09/17/11 at 6:45 AM. The resident continued to display inappropriate sexual behavior according to the behavior monitoring forms for the month of October, November and December of 2011. Redirection was the intervention implemented and staff documented the behavior continued afterwards. The facility continued to allow Resident #4 (the perpetrator) to reside with Resident #21 (the victim) as roommates without supervision and no additional interventions to protect Resident #21 and other residents from potential further abuse by Resident #4. Thus the Administration did not identify failures in the staff not following the policy/procedure, not conducting	F 490		

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F 490	Continued From page 50 a thorough investigation and failure to protect residents from further abuse. An acceptable Allegation of Compliance was received on 02/13/12 and detailed the following: On 02/10/12, the Administrator was trained by the Corporate Compliance Nurse all alleged violation involving mistreatment, neglect, or abuse (specific F225) must be reported to other officials such as the Department of Community Based Services (DCBS) and Office of Inspector General (OIG). There must be evidence that all alleged violation are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting. On 02/10/12, all Charge Nurses, Administrative Nurses, Social Services Director, Administrator and Department Leaders was inserviced on the Abuse, Neglect and Exploitation Policy. Additionally, nurse aide rounds were established and conducted every hour to view the residents, know their whereabouts and assure their environment was free of accident hazards. All residents were assessed by Licensed Nursing staff utilizing the Residents at Risk for Abuse Assessment form, observation and interview. On 02/10/12, Resident #4 was placed on one to one supervision and remained on continuous monitoring. Verification of the removal of Immediate Jeopardy was completed as follows:	F 490		

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F 490	Continued From page 51 Review of the Residents at Risk for Abuse Assessment revealed all residents within the facility had an assessment completed on 02/13/12. A review of the inservicing form, dated 02/10/12, and interview with the Administrator, revealed she was re-educated on 02/10/12 related to ensuring all allegations were thoroughly investigated and reported to the other officials. Interview with Licensed Staff and aides, on 02/13/12, revealed they had received inservicing on 02/10/12 related to abuse, separating the residents, placing the aggressor on one to one supervision and notifying the Administrative Nurse on-call. Additionally, the nurses would start the investigation and get statements from all staff working at the time of the incident. They would also interview the residents to see if they had any knowledge of the incident. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Based on interview and record review, it was determined Immediate Jeopardy was identified on 02/10/12 and determined to exist on 09/14/11 through 02/13/12. An acceptable Allegation of Compliance (AoC) was received on 02/13/12. Immediate Jeopardy was removed, effective 02/14/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care.	F 490		

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F 490	Continued From page 52 (Refer to F225 and F323)	F 490	**F505**	
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promptly notify the attending physician of laboratory findings for one resident (#13), in the selected sample of fifteen residents. A urinalysis was ordered on 12/13/11 with the initial abnormal results faxed to the physician on 12/15/11. The urine culture results were received and faxed on 12/17/11; however, an order for antibiotic therapy was not received until the physician was in the facility, on 12/22/11. Findings include: A review of the facility's policy/procedure, "Diagnostic Services," revised 03/16/10, revealed the results of laboratory and diagnostic services would be reported in writing to the resident's physician. Test results should be promptly forwarded to the physicians and the charge nurse, or designee, would be responsible for notification of the physician. A record review revealed Resident #13 was readmitted to the facility on 05/07/10 with diagnosis to include Urinary Tract Infection. A review of the quarterly Minimum Data Set (MDS), dated 01/12/12, revealed the facility assessed the	F 505	**Resident #13** **1. Corrective Action:** Resident #13's primary care physician was notified on 12-22-11. On 2-10-12, the Director of Nursing provided inservice education to licensed nurses on the Policy and Procedure on Diagnostic Services to include that physicians will be notified timely per telephone of abnormal values/results of laboratory services. **2. ID of Other Residents:** DON, ADON and Compliance Nurses reviewed lab results for all residents in the past 3 months on March 3, 2012, and March 4, 2012, for the notification of the family and physician and follow-up if needed. One omitted family contact identified, family member was called and indicated that he was already aware of lab and new order. were found in the review. **3. Preventative Measures:** On 2-10-12, the Director of Nursing provided inservice education to licensed nurses on the Policy and Procedure on Diagnostic Services to include	

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F 505	Continued From page 53 resident to be moderately cognitively impaired and occasionally incontinent of bladder. A review of the Physician's orders, dated 12/13/11, revealed a urinalysis was ordered for the resident related to confusion. A review of the initial urinalysis results, dated 12/15/11, revealed the abnormal results were faxed on 12/15/11 by Licensed Practical Nurse (LPN) #4. An interview with LPN #4, on 02/09/12 at 3:20 PM, revealed she faxed the results of the urinalysis, on 12/15/11, to the Primary Physician for Resident #13; however, she did not call the physician. She revealed she should have also notified the physician by phone, as the results were abnormal. A review of the urine culture results, dated 12/17/11, revealed the results were faxed on 12/17/11 by LPN #1. An interview with LPN #1, on 02/09/12 at 4:00 PM, revealed she faxed the results, on 12/17/11, to the Primary Physician for Resident #13, but should have also notified the physician by phone. She revealed it would be charted in the nurse's notes if the physician was notified by phone. There was no evidence in the nurse's notes that the results of the urinalysis or urine culture were called to Resident #13's Primary Physician. A review of the Physician's orders, dated 12/22/11, revealed an order for Ampicillin (antibiotic therapy) 500 milligrams (mg) four times daily for seven days due to a urinary tract infection. A review of the nurse's notes, on 12/22/11 at 8:00 AM, revealed the Primary	F 505	that physicians will be notified timely per telephone of abnormal values/results of laboratory services. All newly hired Licensed Nurses will receive the same training by the Corporate Nurse Educator in the orientation process. **4. Monitor:** The Director of Nursing will provide monthly audits of a minimum of 5 medical records to ensure that the physician/family is notified timely per telephone of all abnormal laboratory results for 3 months or until issue is resolved. Results of the monthly audits will be reported monthly to the facility Quality Assurance Committee for review and/or intervention. Members of the Quality Assurance Committee include the Administrator, Director of Nursing, Department Managers, and the Medical Director. **5. Completion date:** **See Exhibit #8**	3-5-12

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F 505	Continued From page 54 Physician for Resident #13 was in the facility and reviewed the laboratory results at that time. An interview with Resident #13's Primary Physician, on 02/09/12 at 10:15 AM, revealed 12/17/11 was on a Saturday, and the faxes in his office "probably piled up over the weekend." He stated he was not sure what happened. An interview with the Director of Nursing (DON), on 02/09/12 at 7:15 PM, revealed she expected the staff to notify the physician, by phone, if abnormal laboratory results were received. If abnormal results were received on a weekend, she expected the nurse to notify the physician on-call.	F 505		

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N 000	INITIAL COMMENTS AMENDED 03/08/12 A re-licensure survey and complaint survey (KY #17770) was conducted on 02/07/12 through 02/14/12 to determine compliance with State licensure requirements. The facility was found to not meet minimum State licensure requirements with deficiencies cited and determined to be a violation which presented imminent danger to a resident and created substantial risk that death or serious physical or mental harm could occur in the areas of 902 KAR 20:300. The facility was notified of the determination on 02/10/12. A Type A Citation was issued on 02/15/12 pursuant to KRS 201.555 and KRS 216.557 and 902 KAR 2:040 for violations of 902 KAR 20:300 Section 5 (3) b, 902 KAR 20:300 Section 8 (7) (b), and 902 KAR 20:300 Section 15. The Type A Citation was verified corrected on 02/14/12. The facility remains out of compliance. KY #17770 was substantiated with deficiencies cited. The facility failed to ensure a thorough investigation was conducted with results reported timely, timely reporting of sexual abuse/exploitation allegation to officials, and failed to prevent further potential abuse involving Resident #4. On 09/14/11, Resident #4, who the facility had assessed and identified as having a history of sexually inappropriate behaviors, was observed by facility staff to be in his/her roommates' bed, naked and "humping" his/her roommate (Resident #21). SRNA #2 intervened and Resident #4 returned to his/her bed. Registered Nurse (RN) #2 was informed about the incident and she notified the Assistant Director of Nursing (ADON). RN #2 started every fifteen (15) minute checks on Resident #4. There was no evidence the facility followed their "Abuse"	N 000	 DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Tradewater Pointe, d/b/a Tradewater Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Tradewater Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Tradewater Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Administrator — TITLE — (X6) DATE: 5-1-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/08/2012

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1971 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (111) SMOKE COMPARTMENTS: Three (3) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors . SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 02/08/12. Tradewater Pointe was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds and the census was fifty eight (58) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		

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OFFICE OF INSPECTOR GENERAL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Center | Director | 3-9-12.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	~~K018~~ **1. Corrective Action:** Hinged wooden gates were removed by the Maintenance Director on 2-9-12 from rooms #214, 215, 216, 200, 203, And 205.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in corridors were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the	K 018	**2. ID of Other Residents at Risk:** All residents at risk due to gates impeding access to the room door to enable closing. **3. Preventative Measures:** Hinged wooden gates were removed by the Maintenance Director on 2-9-12 from rooms #214, 215, 216, 200, 203, And 205. **4. Monitor:** (Wooden gates have been removed.) Maintenance Director will review doors in the building monthly and report to the facility CQI Committee using the CQI Maintenance Tool, Review of Buildings and Grounds. Problems with any doors will be corrected and reported.	

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K 018	Continued From page 2 survey. The findings include: Observation, on 02/08/12 between 3:07 PM and 5:00 PM, with the Maintenance Director revealed the facility had installed hinged wooden gates on resident room #214, #215, #216, #200, #203, & # 205 to prevent wandering residents from entering these rooms. Further observation revealed the gates when closed impede access to the room door to enable closure during a fire. Interview, on 02/08/12 at 5:00 PM, with the Maintenance Director revealed the facility had placed the gates on the resident room doorframes due to residents wandering into other resident rooms. Reference: NFPA 101 (2000 Edition). 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and	K 018	The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director. **5. Correction date:**	2-9-12

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K 018	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	**K025** **1. Corrective Action:** Smoke barriers were repaired above the ceiling in rooms 116 & 119 by the Maintenance Director on 3-5-12 to meet standards to prevent the passage of smoke. The drywall was sealed and spaces filled to resist smoke.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025		

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K 025	Continued From page 4 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 at 3:05 PM, with the Maintenance Director revealed the smoke partitions extending above the ceiling at room 116 & 119 has penetrations from wires and pipes, further observation revealed the drywall was not sealed to resist the passage of smoke. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Interview, on 02/08/12 at 3:06 PM, with the Maintenance Director revealed he was unaware of the penetrations. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires,	K 025	**2. ID of Others at Risk:** All residents at risk for accidental fire in a facility. All attic areas of the facility, including between smoke barriers, were reviewed by the Corporate Maintenance Consultant and the facility Maintenance Director on 3-5-12 to assure smoke barriers were in place and effective. No further problems found with smoke barriers. **3. Prevention Measures:** Smoke barriers were repaired by the Maintenance Director on 3-5-12 to meet standards to prevent the passage of smoke. Maintenance Director will routinely check smoke barriers quarterly and check after any outside contractor performs services that might compromise smoke barriers such as cable or computer wire installations.	

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K 025	Continued From page 5 air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	**4. Monitor:** Maintenance Director will check barriers quarterly and after attic installations to check for damage to smoke damage. If any problems are identified, corrections will be made immediately. A report of the reviews will be reported to the facility CQI Committee monthly x 3 months, then quarterly. The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director. **5. Corrective Date:** 3-5-12	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	**K029** **1. Corrective actions:** Self closing door devices added to the kitchen dry storage area, the clean linen closet next to 100 (West) hall, the housekeeping	

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K 029	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 between 3:07 PM and 4:52 PM, with the Maintenance Director revealed the doors to the kitchen dry storage, the clean linen closet next to 100 hall, the housekeeping closet on 200 hall, and the oxygen storage room did not have a self closing device. Interview, on 02/08/12 at 4:52 PM, with the Maintenance Director revealed they were not aware the doors needed a self closing device. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic	K 029	closet on 200 (East) hall and the oxygen storage room by the Maintenance Department on 3-6-12. **2. ID of Other Residents at Risk:** All residents at risk for fire in a facility. **3. Preventative Measures:** Self closing door devices added to the kitchen dry storage area, the clean linen closet next to 100 (West) hall, the housekeeping closet on 200 (East) hall and the oxygen storage room by the Maintenance Department on 3-6-12. **4. Monitor:** Maintenance Director will check self-closing doors for proper operation and report to the facility CQI Committee using the Preventative Maintenance Check CQI Tool. A report of the reviews will be reported to the facility CQI Committee monthly x 3 months, then quarterly. If any problems are identified, corrections will be made immediately.	

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K 029	Continued From page 7 extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director. **5. Corrective Date:** 3-6-12 **K038** **1. Corrective actions:** Signage, durable, readily visible, 1 inch letters on a contrasting background: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS placed at both ends of the East and West halls, and the two side exits from the dining room on 3-8-12. Sidewalk contracted for construction 3-8-12 for the east exit of the dining room towards the gazebo	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 between 2:30 PM and 5:30 PM, with the Maintenance Director revealed the delayed egress doors located at both ends of the east and west wings, and the two side exits from the dining room, did not have the required signage stating the door was equipped with a fifteen (15) second delay before opening. Interview, on 02/08/12 at 5:30 PM, with the Maintenance Director revealed they were not aware the delayed egress signage has to be on the exit doors. Observation, on 02/08/12 at 4:40 PM, with the Maintenance Director revealed the east exit of the dining room towards the gazebo does not have a durable surface to a public way. Interview, on 02/08/12 at 4:41 PM, with the Maintenance Director revealed he was unaware the exit needed a durable surface to the public way.	K 038	~~to prepare a durable surface~~ to a public way and is to be installed as soon as weather permits. 2. ID of Other Residents at Risk: All residents at risk for a need to exit the building in an emergency. **3. Preventative Measures:** Signage, durable, readily visible, 1 inch letters on a contrasting background: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS placed at both ends of the East and West halls, and the two side exits from the dining room. 3-8-12 D.O. Sidewalk contracted ~~2-16-12~~ for the east exit of the dining room towards the gazebo to prepare a durable surface to a public way and is to be installed as soon as weather permits. **4. Monitor:** Exits and walkways will be monitored by the Maintenance	

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K 038	Continued From page 9 Exits must have a durable surface to the public way to support wheelchairs, beds, equipment, etc., in case of an emergency situation. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.	K 038	Director and reported to the facility CQI Committee monthly (ongoing) utilizing the Preventative Maintenance CQI reporting tool. The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director. **5. Date corrected:** 3-8-12 See Exhibit #9	

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K 038	Continued From page 10 (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm)	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWATER POINTE	100 W. RAMSEY DAWSON SPRINGS, KY 42408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 10 (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm)	K 038		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 11 and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	**K045** **1. Corrective action:** The exterior exit at the back west exit, and the two front east and west exits now have two fixtures providing two bulbs at the exits. Maintenance Director and contractor installed fixtures on 2-14-12.	

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K 045	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 between 2:30 PM and 4:30 PM, with the Maintenance Director revealed the exterior exit at the back of the west exit, and the two front east and west exits were equipped with a single bulb for illuminating egress path to the public way from the exit. The observation was confirmed with the Maintenance Director. Interview, on 02/08/12 at 4:30 PM, revealed the Maintenance Director was unaware the lighting fixtures serving the exterior exits must include more than one bulb. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. Reference: NFPA 101 (2000 edition) Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any	K 045	**2. ID of Other Residents at Risk:** All residents are at risk for the need to exit the building in an emergency. **3. Preventative Measures:** The exterior exit at the back west exit, and the two front east and west exits now have two fixtures providing two bulbs at the exits. Maintenance Director and contractor installed fixtures on 2-14-12. **4. Monitor:** Exits and lighting will be monitored by the Maintenance Director and reported to the facility CQI Committee monthly (ongoing) utilizing the Preventative Maintenance CQI reporting tool. The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director. **5. Date corrected:**	2-14-12

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K 045	Continued From page 13 designated area.	K 045		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 between 2:30 PM and 5:30 PM, with the Maintenance Director revealed	K 056	**K056** **1. Corrective action:** Porches were evaluated by Armor Fire Protection Company 3-5-12 for installation of sprinkler heads. Heads ordered 3-5-12 to be attached to the automatic sprinkler system with installation upon arrival. Sprinkler heads with the same response time were ordered 3-5-12 and contracted for installation upon arrival to replace the compartment sprinklers located in the Administrative hall of the facility. **2. ID of Other Residents at Risk:** All residents are at risk for fire emergencies in the building, however, there are no residents located in this area of the building. 3. Preventative Measures: Porches were evaluated by Armor Fire Protection Company 3-5-12	

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K 056	Continued From page 14 that the 2 exits on the 100 hall and the 2 exits on the 200 hall do not have sprinkler coverage under the porches that extend over 4' and are made of combustible material. Interview, on 02/08/12 at 5:30 PM, with the Maintenance Director revealed he was not aware the porches needed to be sprinkler protected.. Observation, on 02/08/12 at 5:22 PM, with the Maintenance Director revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located in front of medical records in the administration hall. Interview, on 02/08/12 at 5:22 PM with the Maintenance Director revealed he was not aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	for installation of sprinkler heads. Heads ordered 3-5-12 to be attached to the automatic sprinkler system with installation upon arrival. Sprinkler heads with the same response time were ordered 3-5-12 and contracted for installation upon arrival to replace the compartment sprinklers located in the Administrative hall of the facility. **4. Monitor:** Required safety checks completed by contractor quarterly and reported to the administrator and corporate office. The sprinkler system will be monitored by the Maintenance Director and reported to the facility CQI Committee monthly (ongoing) utilizing the Preventative Maintenance CQI reporting tool. The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director. **5. Date corrected:**	3-5-12
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12, between 2:33 PM to 5:30 PM, with the Maintenance Director revealed the sprinkler heads throughout the facility were not being properly cleaned. Not maintaining sprinkler heads can decrease their ability to react as intended. Interview, on 02/08/12 between 2:33 PM to 5:30 PM, with the Maintenance Director revealed that he was not aware the sprinkler heads were not being properly cleaned. Observation, on 02/08/12 at 3:58 PM, with the Maintenace Director revealed a sprinkler head located in the area behind the dryers was not extended below the ceiling. Interview, on 02/08/12 at 4:00 PM, with the Maintenance Director, revealed he was unaware that the sprinkler head was not installed properly.	K 062	~~K062~~ **1. Corrective action:** Sprinkler heads were cleaned by the Maintenance Department on the West wing on 2-9-12 and on the East wing 2-15-12. Armor Fire Protection Company evaluated 2-13-12 and ordered replacement parts 3-5-12 to correctly position and replace sprinkler head located in the area behind the dryers upon arrival. **2. ID of Other Residents at Risk:** All residents are at risk for fire emergencies in the building. **3. Preventative Measures:** Maintenance Director inserviced by Administrator 3-5-12 that sprinkler heads must be cleaned and maintained on an ongoing basis. Armor Fire Protection Company evaluated 2-13-12 and ordered replacement parts 3-5-12 for sprinkler head located in the area behind the dryers with installation upon arrival..	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 062	Continued From page 16 Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 062	**4. Monitor:** Sprinkler head location and cleaning will be monitored by the Maintenance Director and reported to the facility CQI Committee monthly (ongoing) utilizing the Preventative Maintenance CQI reporting tool. The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director.	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey.	K 070	**5. Date corrected:** 3-5-12 **K070** **1. Corrective Action:** Portable space heaters were removed from the Dietary Manager's office and the Director of Nursing's office. 2-8-12. 2. ID of Other Residents at Risk: All residents are at risk for fire emergencies in the building, however no space heaters have been allowed in resident areas and any located in offices were removed from the building.	3-5-12

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K 070	Continued From page 17 The findings include: Observation, on 02/08/12 at 4:30 PM, with the Maintenance Director revealed a portable space heater located in the Dietary Manager ' s Office and the Director of Nursing Office. Interview, on 02/08/12 at 4:30 PM, with the Maintenance Director revealed they were not aware the heaters could not exceed 212°F in nonsleeping staff and employee areas. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). Reference: NFPA 13 (1999 edition) 4-2.5.2 Valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect the dry pipe valve and supply pipe against freezing.	K 070	**3. Preventative Measures:** A check of the building was completed by the Maintenance Department on 2-8-12 and all space heaters removed from the building. Office/Department Leader staff, including the Dietary Manager and the DON were educated in the staff meeting at the end of the day 2-8-12 as to the ban of space heaters from the building. **4. Monitor:** Space heater ban will be monitored by the Maintenance Dept monthly x 3 months and then quarterly. Any found will be removed immediately and the Administrator notified. Findings will be reported to the facility CQI Committee. **5. Date corrected:**	2-9-10
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No	K 072		

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K 072	Continued From page 18 furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 between 3:35 PM and 5:00 PM, with the Maintenance Director revealed linen carts, coffee cart, and lift carts were being stored in the 100 and 200 corridors. Interview, on 02/08/12 between 3:35 PM and 5:00 PM, with the Maintenance Director revealed the facility routinely stored the carts in the corridor. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	**K072** **1. Corrective action:** Linen carts, coffee cart, and lifts were removed by Administrator from storage in the hallways of the 100 and 200 halls on 2-8-12. Staff directed by Adm 3-6-12 to use totes for transporting dirty linens to the dirty linen room, store lifts in the designated storage areas on the East hall and instructed the Dietary Manager to utilize the coffee carts only during meal service so as to limit the time to less than 30 minutes for the cart to be on the halls. **2. ID of Other Residents at Risk:** All residents at risk for fire emergencies and the need to have means of egress that are free of obstructions. **3. Preventative Measures:** Supervisory Staff directed by Adm 3-6-12 to use totes for transporting dirty linens to the dirty linen room, store lifts in the designated storage areas on the East hall and instructed the Dietary Manager to utilize the coffee carts only during meal service so as to limit the time to less than 30 minutes for the carts to be on the halls.	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains,	K 074		

4. Monitor:
Nurse aides will monitor halls for stored equipment on hourly rounds. Any found not to be in use will be properly stored and Charge Nurse notified. Charge Nurse will check halls on shift rounds with any equipment out of place corrected.

The Environmental Services Department/Maintenance Department will monitor equipment storage on their CQI Life Safety Tool daily x 1 month, weekly x 1 month monthly x 1 month and quarterly thereafter.

5. Correction Date: 3-6-12

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K 074	Continued From page 19 and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 at 5:05 PM, with the Maintenance Director revealed the privacy curtains within the shower rooms located in the	K 074	**K074** **1. Corrective Action:** Curtains with 18" mesh ordered for the 100 and 200 shower rooms from Direct Supply on 2-15-12 and will be hung upon arrival. **2. ID of Other Residents at Risk:** All residents at risk for fire emergencies. **3. Preventative Measures:** Curtains with 18" top mesh to replace current shower curtains upon arrival. **4. Monitor:** The Environmental Services Department/Maintenance Department will monitor privacy curtains to assure that they allow the 18" unobstructed below sprinkler heads on their CQI Life Safety Tool monthly x 3 months, and quarterly thereafter. **5. Correction Date:**	2-15-12

See Exhibit #9

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K 074	Continued From page 20 100 & 200 Hall shower rooms, had only 12 " of mesh instead of the required 18 " . Interview, on 02/08/12 at 5:05 PM, with the Maintenance Director revealed they were aware of the requirements for proper operation of the sprinkler system. He said they had just ordered these curtains about two weeks before the survey and the company must have sent the wrong size mesh. NFPA 13 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWATER POINTE	100 W. RAMSEY DAWSON SPRINGS, KY 42408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 21 for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 at 4:52 PM, with the Maintenance Director revealed there was no signage indicating full or empty oxygen tanks in the oxygen storage room. Interview, on 02/08/12 at 4:52 PM, with the Maintenance Director revealed he was not aware the oxygen tanks needed signage indicating full or empty.	K 076	**K076** **1. Corrective Action:** Signage indicating full or empty oxygen tanks were added to the "empty" and "full" carriages in the oxygen storage room by the Maintenance Department on 2-9-12. **2. ID of Other Residents at Risk:** All residents at risk for fire from improper storage/labeling of oxygen. **3. Preventative Measures:** Signage indicating full or empty oxygen tanks were added to the "empty" and "full" carriages in the oxygen storage room by the Maintenance Department on 2-9-12. **4. Monitor:** The Environmental Services Department/Maintenance Department will monitor Oxygen Storage to assure that labels remain in place for empty and full containers of oxygen and report findings to the facility CQI Committee monthly x 3 months, and quarterly thereafter. **5. Correction Date:**	2-9-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185133	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWATER POINTE	100 W. RAMSEY DAWSON SPRINGS, KY 42408

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K 076	Continued From page 22 Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076		
K 130 SS=D	NFPA 101 MISCELLANEOUS	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWATER POINTE	100 W. RAMSEY DAWSON SPRINGS, KY 42408

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K 130	Continued From page 23 OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 02/08/12 at 4:05 PM, with the Maintenance Director revealed a heavy build up of lint behind the washer and dryer and in the top of the dryer, in the Laundry Room. Interview, on 02/08/12 at 4:05 PM, with the Maintenance Director revealed he was not aware the lint build up was so excessive. Reference: NFPA 101 (2000 Edition)	K 130	**K130** **1. Corrective Action:** Heavy build up of lint removed by the Maintenance Director on 2-8-12, from behind the washer and dryer and in the top of the dryer in the Laundry Room of the facility. **2. ID of Other Residents at Risk:** All residents at risk for fire from lint build up. **3. Preventative Measures:** Maintenance Director to check and remove any lint build up weekly x one month and ongoing to assure no heavy accumulation had been deposited. Laundry Supervisor instructed by Administrator on 3-6-12 to keep check on area for lint build up as well and remove as needed. Laundry staff inserviced by Environmental Services Supervisor on 3-6-12 to remove lint from dryers after each load.	

4. Monitor:
The Laundry Safety Inspection CQI Tool and the Preventative Maintenance Tool will be utilized to monitor weekly ongoing for the Maintenance Tool, weekly x 1 month Laundry Safety Inspection, then monthly x 3 months and quarterly. Findings will be reported to the facility CQI Committee monthly.

The CQI Committee consists of the Administrator, the Medical Director, DON, ADON, Compliance Nurse, Maintenance Director, HKSP Dir, Activities Director, and Food Service Director.

5. Correction date: 3-6-12